STATE OF UTAH
DEPARTMENT OF HEALTH
Division of Health Care Financing
2870 Connor Street, Room 157
Salt Lake City, UT 84109

FACILITY COST PROFILE

I, _____ (Name)

OF _____ (Name of Long Term Care Facility)

_____ (Address)

_____, _____, _____ (City) (State) (Zip)

Mailing address if different than facility address:

_____

_____ (Address)

_____, _____, _____ (City) (State) (Zip)

I HEREBY CERTIFY that the information provided in this Facility Cost Profile Report and any supporting information included with it is true, accurate and complete as prepared from the books and records of the Nursing Home, in accordance with applicable instructions except as noted. I further certify that all items of expense indicated in this report were actually incurred and were necessary, reasonable, and related to patient care. I hereby agree to keep for a period of no less than five (5) years such records as are necessary to disclose fully the information contained herein and further agree to make said records available at the request of authorized state personnel to include but not be limited to agents of the Departments of Health and Social Services and the Bureau of Medicaid Fraud. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF RATES WHICH MAY BE COMPUTED WILL BE PAID FROM FEDERAL AND STATE FUNDS AND THAT ANY MISREPRESENTATION, FALSIFICATION, CONCEALMENT, OR OMISSION OF MATERIAL FACT CONSTITUTES FRAUD AND MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

FCP REPORT PERIOD _____, 19__ to _____, 19__

_____ (Signature of Owner, Partner or Officer) _____ (Title) _____ (Signature of Preparer) _____ (Title)

_____, 19____ (Date Mailed)

_____, 19____ (Date Prepared)

_____ (Area Code and Telephone No. of Nursing Facility)

_____ (Area Code and Telephone No. of Preparer)

General and Statistical Information
(Check All Blocks Applicable)

A. Type of Facility and Total Licensed Beds

	SNF	ICF	IMR	Residential and Other	Total
____ Hospital	____	____	____	_____	_____
____ Long Term Care Facility	____	____	____	_____	_____
____ Public Medical Institution	____	____	____	_____	_____
____ Other _____	____	____	____	_____	_____

B. Type of Ownership

_____ Proprietary

_____ Partnership
_____ Sub-Chapter "S" Corp.
_____ Corporation
_____ Individual
_____ Other _____ (Specify)

_____ Non-Proprietary

_____ Voluntary Non-Profit
_____ Government
_____ State
_____ County
_____ City
_____ Other _____ (Specify)

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TN 25-85 Supersedes TN 21-85

APPENDIX I

PROVIDER #_____ Schedule A, Cont'd.

The period covered by the most recent audit of our financial records by an independent public accountant was from _____, 19___ to _____, 19__ by:

_____ (Name of Firm) _____ (Address) _____ (Zip)

( ) _____
(Area Code & Telephone Number)

Please submit a copy of the above audit report with your completed cost report. Facilities having records maintained by outside sources must indicate location of records:

_____

_____

D. Is the Administrator, Assistant Administrator, Owner or Officer associated with any other Medicaid facility in Utah?

Yes_____ No_____
If Yes, complete below:

Name of Individual	Facility Assoc. With	Medicaid Provider #	# of Beds	Primary Duty	Salary	% Time Spent at Facility

E. Has there been a change in operations or ownership during the period?

Yes_____ No_____ Explain:_____

_____

_____

_____

F. Were any owners/officers or members of their families living on nursing facility grounds?

Yes_____ No_____
If Yes, complete below:

	Name	Expense Account Apportioned	Amounts Apportioned
1.			
2.			
3.			
4.			
5.			

Explain basis for apportionment on separate schedule. List each expense account, the total expense, describe the methodology for apportionment and include the computation.

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Were services purchased or rentals and leases arranged involving organizations related by common ownership or control for any of the following expense categories?

		Yes	No			Yes	No
1.	Administrator	___	___	5.	Management Fee	___	___
2.	Rental of Facilities	___	___	6.	Housekeeping	___	___
3.	Dietary	___	___	7.	Maintenance	___	___
4.	Laundry	___	___	8.	Accounting Fee	___	___
				9.	Other (Specify)	___	___

If the answer to any of the above is Yes, please attach a schedule which identifies the cost of the services, rentals or lease to the related organization.

H. List below all owners, officers and administrators for whom salaries, wages or drawings have been included as salaries in the FCP.

Were any members of the owners', officers' or administrators' families* on the payroll or recipients of any money?

If YES, add to the list.

Name of Owner, Officer, or Family Member	Age if Less Than 19	% of Time or Hours Per Week	Total Monies Paid or Accrued During During the Period

I. Rates charged during period:

Payor	SNF-1 (Super Skill) Min/Max	IMR-1 (Skilled) Min/Max	ICF-1 (Trans.) Min/Max	IMR-2/ICF-2 (Intermed.) Min/Max	IMR-3 Min/Max	Resid. Min/Max
Private						
Medicaid						
Medicare						
V.A.						
Other (i.e., Residential)						

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APPENDIX I
SCHEDULE B

STATE USE ONLY

(1) PROVIDER # _____
(2) Beginning Report Date _____ (YY MM DD)

(3) COST	(4) ACCT	(5) TITLE	(6) EXPENSES PER GEN. LEDGER	(7) ADJUSTMENTS	(8) FCP REPORTED EXPENSE	(9) AUDIT ADJ. & RECLASS.	(10) AUDITED COST
01	00	GENERAL ADMINISTRATIVE					
	01	Admin. Salary Lic. # _____					
	02	Asst. Admin. Sal. Lic. #_____					
	03	Office Salaries and Wages					
	04	Director Fees					
	05	Payroll Taxes and Emp. Ben.					
	06	Management Services					
	08	Central Office Overhead					
	09	Advertising					
	10	Telephone					
	11	Dues, Subscriptions & Licenses					
	12	Off. Supplies, Print. & Post.					
	13	Legal and Accounting					
	14	Utilization Review					
	15	Travel and Seminars					
	16	Data Processing					
	17	Amortization-Organization					
	18	Taxes					
	19	In-Service Training					
	20	Interest			XXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXX
	21	Income Taxes			XXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXX
	22	Bad Debts			XXXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXXX
	23	Contributions					
	24	Misc.					
	25	Medical Records & Ward Clerk					
	99	TOTAL					
02	00	PROPERTY AND RELATED EXPENSES					
	05	Rent & Lease, Complete (Schedule D or E)					
	06	Real Estate Taxes					
	07	Depr. Bldg. & Imp.					
	08	Depr. Trans. Equip.					
	09	Depr. Equipment					
	10	Interest-Mortgage					
		Insurance					
		TOTAL					

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APPENDIX I
SCHEDULE B, Cont'd.

STATE USE ONLY

(1) PROVIDER # _____
(2) Beginning Report Date _____ (YY MM DD)

(3) COST	(4) ACCT	(5) TITLE	(6) EXPENSES PER GEN. LEDGER	(7) ADJUSTMENTS	(8) FCP REPORTED EXPENSE	(9) AUDIT ADJ. & RECLASS.	(10) AUDITED COST
03	00	PLANT OPERATION & MAINTENANCE					
	04	Salaries and Wages					
	05	Equipment Rental					
	06	Supplies					
	07	Purchased Services					
	08	Repair & Mnt.-Bldg. & Grounds					
	09	Repair & Mnt.-Equip.					
	10	Repair & Mnt.-Trans. Equip.					
	11	Insurance					
	12	Utilities					
	13	Misc. (Attach Schedule)					
	99	TOTAL					
04	00	DIETARY					
	04	Salaries and Wages					
	05	Food					
	06	Food Supplies					
	07	Purchased Services					
	08	Misc. (Attach Schedule)					
	99	TOTAL					
05	00	LAUNDRY AND LINEN					
	04	Salaries and Wages					
	05	Linen and Bedding					
	06	Supplies					
	07	Purchased Services					
	08	Misc. (Attach Schedule)					
	99	TOTAL					
06	00	HOUSEKEEPING					
	04	Salaries and Wages					
	05	Supplies					
	06	Purchased Services					
		Misc. (Attach Schedule)					
		TOTAL					

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APPENDIX I
SCHEDULE B, Cont'd.

STATE USE ONLY

(1) PROVIDER # _____
(2) Beginning Report Date _____ (YY MM DD)

(3) COST	(4) ACCT	(5) TITLE	(6) EXPENSES PER GEN. LEDGER	(7) ADJUSTMENTS	(8) FCP REPORTED EXPENSE	(9) AUDIT ADJ. & RECLASS.	(10) AUDITED COST
07	00	NURSING					
	01	Director of Nursing					
	02	Assistant Director of Nursing					
	03	In-Service Staff					
	04	Salaries and Wages ***					
	05	Med. Supplies-Inc. Med. Req.					
	06	Consultants					
	07	Physician					
	08	Physical Therapy					
	09	Pharmacy					
	10	Speech Therapy					
	11	Laboratory & Radiology					
	12	Oxygen					
	13	Misc. (Attach Schedule)					
	99	TOTAL					
08	00	RECREATIONAL ACTIVITIES & SPECIAL SERVICES					
	04	Salaries					
	05	Purchased Services					
	06	Other (Attach Schedule)					
	07	Sheltered Workshops					
	99	TOTAL					
		TOTAL REPORTED EXPENSES					

PATIENT DAYS

Type	Private	Medicaid	Medicare	V.A.	Other	Total Reported Days	Capacity Beds	Capacity Days	Capacity Total Days	% Occ.	Audit Adj.	Total Allowable Days	Audited % Occ.
SNF													
SNF/I													
ICF													
ICF/MR													
NF													

STAFF FTE DAY

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APPENDIX I

SCHEDULE C-1

PROVIDER # _____

BEGINNING REPORT DATE _____
(YY MM DD)

REVENUE

(3) COST	(4) ACCT	(5) TITLE	(6) FCP REPORTED REVENUE
70	00	MEDICAID REVENUE RELATING TO PERIOD	
	01	Skilled	
	02	Intermediate	
	03	IMR	
	04	Third Party	
	05	Contractual Adjustments	
	06	Patient Refunds	
	99	TOTAL	
71	00	PRIVATE REVENUE RELATING TO PERIOD	
	01	Skilled	
	02	Intermediate	
	03	IMR	
	04	Third Party	
	05	Contractual Adjustments	
	06	Patient Refunds	
	07	Veterans	
	08	Community Discounts	
	09	Residential Care	
	99	TOTAL	
72	00	MEDICARE REVENUE RELATING TO PERIOD	
	01	Medicare	
	04	Third Party (i.e., from patient)	
	05	Contractual Adjustment	
	06	Patient Refunds	
	99	TOTAL	
73	00	OTHER REVENUE NOT OFFSET AGAINST COST	
	01	Other (Attach Schedule)	
	99	TOTAL	
		TOTAL REVENUE RELATING TO PERIOD NOT OFFSET AGAINST OPERATING COSTS	

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APPENDIX I
SCHEDULE C-2

PROVIDER # _____
BEGINNING REPORT DATE _____
(YY MM DD)

CHECKLIST OF
ADJUSTMENTS TO OPERATING EXPENSES

(3) COST	(4) ACCT	(5) TITLE	(6) FCP REPORTED ADJUSTMENTS
75	00	INCOME FROM PATIENTS*	
	01	Telephone	
	02	Laundry	
	03	Dry Cleaning	
	04	Private Nursing Service	
	05	Pharmacy	
	06	Laboratory	
	07	Therapy	
	08	Medical Supplies	
	09	Other (Attach List)	
	99	TOTAL	*
76	00	MISCELLANEOUS INCOME*	
	01	Meals Sold to Guests or Employees	
	02	Room Rented to Employees	
	03	Laundry Services to Employees	
	04	Services & Supplies Sold to Employees	
	05	Telephone Commissions	
	06	Purchase Discounts & Rebates	
	07	Property & Equipment Rentals	
	08	Contributions	
	09	Interest	
	10	Vending Machines	
	11	Gift Shop & Snack Bar	
	12	Barber Shop & Beauty Shop	
	13	Other (Attach List)	
	99	TOTAL	*

*Carry to Schedule B to appropriate Cost Center under Adjustments column.

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APPENDIX I

SCHEDULE D

PROVIDER #_____

Lessor related by common ownership or control with lesses? Yes_____ No_____.
If YES, attach explanation and complete Schedule E.

BUILDING RENTAL

(To be completed by nursing facilities with unrelated leases only).

1. _____ (Name of Lessor) _____ (Address) ( ) _____ (Telephone Number)

2. Period of Lease _____, 19___ to _____, 19___.

3. Annual Gross Rental Fee (Per Lease Contract) less the following if included in Gross Rental:

4. Rental of Movable Equipment:	$_____	846*
5. Real Estate Taxes:	_____	844*
6. Building Insurance:	_____	848*
7. Utilities:	_____	854, 853, 855*
Other Expenses (Attach List):	_____	859*
9. Total (4 + 5 + 6 + 7 + 8)		$_____
10. Net Building Rental (3 - 9)		$_____ 843*

11. Cost Per Bed _____ or Cost Per Square Foot _____.

*Include in Schedule B as an adjustment to the corresponding account code(s).

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